

## **AMCHP 2008 ANNUAL CONFERENCE**

### **WE ARE MAKING A DIFFERENCE:**

#### **Healthy Weight in Women: The Importance of Collaboration**

March 1st to 5th, 2008

LOIS BLOEBAUM: Good morning. I'd like to thank CityMatCH and AMCHP for the invitation to speak to you today and also thank them very much for the opportunity to participate in the collaborative.

I'm going to talk to you a little bit today about some background in weight issues among reproductive age women in Utah and then I'm going to focus on our action learning collaborative process and then talk a little bit about some of the interventions that we've developed during this past 16 months.

So as Brenda mentioned, the aim was basically to build state and local capacity for healthy weight initiatives, and Utah was one of the eight states who applied and was chosen to participate.

Our team was comprised of partners from the Department of Health, the University of Utah Center of Excellence in Women's Health, the Salt Lake Valley Health Department and members of our WIC programs both at the state and local level.

I just want to give you a little background quickly about our weight issue in Utah. According to behavioral risk factor surveillance data over 42 percent of reproductive age women reported that their BMI was overweight or obese. About a quarter, just over a quarter of women are reporting eating five or more fruits and vegetables a day. And in Utah we were surprised we do a little bit better, probably due to our outdoor recreation in the state on recommendations for moderate or physical -- our vigorous physical activity.

According to our vital records data about 35 percent of women who delivered a live birth were overweight or obese prior to pregnancy, which is 30 percent increase in the last decade, and a huge percentage, almost 68 percent reported exceeding the institute of medicine's weight gain guidelines. So that's another area that we are working towards.

PRAMS data found that women who were obese prior to pregnancy were at increased risk of developing diabetes, hypertension, having a macrosomic infant, having labor induced, having their infant admitted to the NICU and reporting postpartum depression.

And then these are the characteristics of the women that we were targeting. Lower education levels tended to be multiparous, tended to be at 200 percent below the federal poverty level and a higher percentage enrolled in WIC. We

therefore decided to target our interventions towards the WIC population in Salt Lake Valley, which is our largest urban health center.

So our short-term goals sort of mirroring what CityMatCH and AMCHP wanted to establish was basically, you know, pulling together these diverse partners, and as I'll talk about throughout the presentation that was easier said than done. You know, we've been at this for 16 months, and it's difficult. That's probably one of the most difficult issues that we had to deal with was everyone has competing priorities, and getting them to the table around this issue was challenging.

We also wanted to target our interventions so that they were culturally and linguistically appropriate for our populations and so we wanted to start out by conducting focus groups with WIC enrollees, and then the idea was to implement the intervention among that target group and try to find some funding in which to do so because the collaborative did not provide funding, just travel support and facilitation.

So our mid-term goals were to increase awareness among WIC enrollees of the importance of achieving and maintaining a healthy weight, evaluate the feasibility of implementing an intervention and evaluate the effectiveness of the chosen intervention. Lofty goals in a 16 month period.

Long term we wanted to increase the proportion of targeted WIC enrollees who achieve and maintain a healthy weight, consume the recommended daily amount of fruits and vegetables, accomplish the recommended amount of daily physical activity and enter subsequent pregnancies at a healthy weight and achieve the recommended weight gain.

And we wanted to be able to at the end of the day still be friends and partners.

Some of our activities involved key informant surveys among WIC staff to identify what their insights into the issue are, since they were going to be helping us implement the intervention we wanted to hear first from them. The focus groups we held with four groups of pregnant and/or -- no, you can't be and/or, pregnant or postpartum women who are overweight or obese to identify assets and barriers.

We also one of our team members was an obstetrician from the University of Utah, and she was particularly interested in the provider role for healthy weight, and so we wanted to conduct a chart review to see what provider practices were regarding this issue.

And then lastly implementation of our intervention, which I'll talk about in a little more detail later.

So we had a good captive audience with our key informant surveys, and we enrolled WIC RD, who was also working on her MPH at the time and needed a project to do those key informant interviews, to conduct the focus groups for us, and to do some training among WIC staff.

From the key informant interviews we did work with the WIC program at Salt Lake Valley and developed some brochures addressing issues that the RDs identified during the key informant surveys. Focus groups, as I said we held four of them, two with Spanish speaking women, two with English speaking women. We received some funding from region eight office of women's health to provide incentives to the women and light healthy refreshments.

We had basically four areas that we wanted to focus on. We wanted to learn about what their perceptions of healthy weight were, what they knew about healthy eating and physical activities and some other issues as you'll see as I get into the themes.

These were the findings. Not a lot that we didn't already presume, but it's always good to have confirmation of your assumptions so some of the themes were healthy weight differs according to individual circumstances in genetic background. There was sort of this theme that you know I'm the weight I am because of my genetics and I can't do anything about it.

Overall opinions were variable concerning the effective weight on health. There really wasn't a solid understanding of women connecting, especially pregnancy health connecting pregnancy outcomes to overweight and obesity, so we have a lot of work to do in that area.

Because we are -- we had in mind the bright futures, intervention which involves health care provider assessment and counseling we want to know what women felt about addressing the issue with their providers, and they were very positive about that. We also examined barriers to healthy eating which included unsupportive spouses and families, cost and time. Our Hispanic participants noted cultural beliefs that encourage overeating so, you know, a healthy baby is a fat baby and therefore you need to eat whatever you want.

And then enablers to healthy eating included wanting to prepare healthy meals for kids, for their children. And also peer support. There was a lot of interest in support groups.

Barriers being physically active included physical limitations, time, finances, lack of child care, not making it a priority.

Enablers to being physically active included setting goals, support, being able to purchase exercise equipment and a positive attitude and walking was by far the most popular cited type of physical activity.

Moving on to the chart review process, we did a prenatal medical record review at the University of Utah and Salt Lake Valley Health Clinics. We looked at prepregnancy height and weight, whether it was recorded, whether the BMI was calculated, and if the BMI was greater than 30 was it listed as a problem on the problem list.

And here's our findings. Over 300 charts were reviewed at 30 weeks or greater gestational age. Weight was recorded 99 percent of the time at the first prenatal care visit but only 32 percent of the weights were plotted over pregnancy. 20 percent of heights and prepregnancy weight were documented. Less than 10 percent of the time BMI was calculated and of the women who were noted to be overweight or obese at the first visit only 18 percent had documentation of a problem on their problem list. So a lot of work to do in regards to provider education in this area.

And now I want to talk about the fourth activity that we sort of focused on and came upon this through the 16 month collaboration and looking for something that we could do that would be low budget and effective, and so we settled on the my bright futures intervention, which is a new initiative to empower women across the lifespan to seek preventative health service, share in decision making and practice prevention in their daily lives.

Basically bright futures include guides for both adult and young women and take home a take home wallet card and reaching my tip goal sheets as handouts that the provider can provide to the woman.

It also includes a counseling support tool that provides information on how to review the patient's answers to the questions, guidance on how to make recommendations based on patient's answers.

I'm going to skip through this, since I've gotten a five-minute warning call. Suffice it to say that what we -- that we're really excited about this curriculum, because it addresses weight, healthy weight education in the women and also in the providers, and evidence is showing that women really do adhere to recommendations from their providers.

I'm just going to take a minute and pass the curriculum around since I don't have a lot of time to talk about it. The guides have been pilot tested and basically HIRSA has found that using the guide only adds a few minutes to the visits, it greatly enhances and facilitates patient discussion on these two issues and works well with all patients. And one of the things we heard from providers was that, you know, what if we identify obesity as a problem, what do we do about it? And so this provides really concise tools and information for the provider to quickly counsel a woman and begin helping her make goals towards reducing her weight.

The pilot testing was very positive among women as well. I just want to briefly mention that the bright futures is being evaluated through Alteram Research, HIRSA's contracted with Alteram to do a large multicenter study, and Utah is one of the states that's going to be participating in the national evaluation.

Basically we're targeting women at three Salt Lake Valley health clinics presenting for postpartum care or routine gynecological care because we're interested in knowing what is the most on tune time to intervene with a healthy weight message.

Alteram is providing us with the materials which I forgot to mention are free from HIRSA which was a really enticement for us. But we are also providing incentives to women because the assessment tool that they'll be asked to complete is about a 20, 23 question tool and takes a little bit of time so we're excited to see the results from that.

So action, learning collaborative, lessons learned. Basically as I mentioned previously, the tough thing was keeping a diverse group of stakeholders engaged, coordinating, communicating effectively.

I attended a leadership skills building session on Saturday and one of the speakers said you know, being a leader is, you know, really important because

you have the vision and but you also have to be a good manager and he likened, you know, if you're not effective, you're like a home-run hitter who forgets to touch the bases.

And I have to admit some of the bases were skipped over at times, and I think that's probably one of the biggest lessons that I learned is the detail is in the -- the devil's in the detail. Myself and Audrey Stephenson from Salt Lake Valley Health Department, we're the co-leaders of the group. And so it was challenging to keep this diverse group together, but I think we succeeded. We've kept our core group very active and the train is sort of loaded and ready to leave the station. So we're very excited about our work.

We did have difficulty recruiting participants for the focus groups. We don't know whether it was due to the issue, you know, women didn't want to -- they felt singled out because they were overweight or obese and didn't want to talk about these issues, even though we did have a \$50 incentive for women's participation or whether the recruitment was difficult due to competing priorities of our WIC staff.

We had some difficulty getting translation and transcription of our Spanish focus groups, so those things definitely stalled our work.

What worked well as I mentioned, our core group remain engaged and excited to continue the implementation of the things that we've started. There was a really nice complement of skills and knowledge on the team state, local, and academic, all had major roles to play in this work, and we couldn't have done it without the three of them. And as I mentioned, we had an MPH student volunteer who was absolutely essential in implementing the focus groups and basically sharing of ideas and strategies between other state teams.

You know, we had numerous calls throughout the 16 month period, some other states were also conducting focus groups, were developing discussion guides, and you know the ability to be able to share that knowledge and not reinvent the wheel was absolutely imperative.

Advice for others. WIC provides a good population and in our state as I mentioned they were overrepresented among our overweight populations. Important to have a firm idea of the project before selecting stakeholders. Know what materials have already been developed like the bright futures and know your population, so the focus groups were really helpful to help us develop the interventions.

Just lastly a little bit about sustainability. As I mentioned, bright futures will be implemented in these three Salt Lake Valley clinics. We're also doing some work

about in regards to healthy weight gain during pregnancy, education for both providers and women.

And lastly, we are undertaking a process of educating Utah RDs and health care providers regarding Medicaid coverage for counseling high risk women. The enhanced, package of enhanced services for prenatal Medicaid women includes seven hours of one-on-one counseling with a registered dietician. We did a little investigation and realized that that was not being utilized and the reason was because the reimbursement rate was about \$12 an hour.

So we negotiated with our Medicaid program and easily, surprisingly easily for working with Medicaid got our reimbursement rate increased to about \$60 an hour. And so now we're educating educators and RDs across the state that this service is available and that it should be utilized. So we're excited about that work.

So that's all for me. Questions. Or are we holding questions to the end? We're holding questions to the end. Okay. Thank you.